Implementation of the CAP-MR/DD Clinical Policy/Manuals and Technical Amendment Number One

These "Talking Points" serve as additional clarifying information to be used with the presentation- ***CAP-MR/DD Clinical Policy, Technical Amendment and Manuals.***

The *CAP-MR/DD Clinical Coverage Policy 8M* is the official reference document for specific information regarding the CAP-MR/DD Comprehensive and Supports Waivers. CAP-MR/DD Clinical Policy 8M is located at: http://www.dhhs.state.nc.us/dma/mp/8M.pdf

Section One (slides 4 through 21): Technical Amendment Number One

- ❑ The contents of the Technical Amendment were made within the current waiver application on CMS website (changes from the original waiver)
- ❑ Changes made within the Technical Amendment are effective 11-1-08 unless otherwise indicated.
- ❑ The waiver documents as provided on the CMS, DMH-DD-SAS and the DMA websites are the current waivers inclusive of the Technical Amendment.
- ❑ There is **not** a separate document for the Technical Amendment.
- ❑ The Waiver application is web-based and on the CMS website.

Technical Amendment Number One provides changes/clarifications to both the Comprehensive Waiver and the Supports Waiver in the following areas:

- ❑ Revision to the **Behavioral Consultant** service definition:
  - **Behavioral Consultant now has Level II and Level III.**
  - These levels are intended to provide an increasing level of support based on the intensity of need of the participant.
  - **Behavioral Consultant II:**
    - Intended for individuals whose intensity of need is greater than what can be accommodated by other available waiver (Specialized Consultative Services) and Medicaid community services.
    - **Required Staff Qualifications**
      - *Licensed* psychologist, *Licensed* psychological associate or *Licensed* social worker;
      - Board certified Behavior Analysis or 2 years supervised experience with I/DD and extreme challenging behaviors (functional behavioral assessments, development and monitoring behavior plans)
  - **Behavioral Consultant III**:
      - Is intended for individuals who exhibit severe aggression, self-injury, and other dangerous behaviors.
      - Level III requires staff with a higher level of experience working with individuals with these extreme behavioral challenges.
      - **Required Staff Qualifications**

- *Licensed* Psychologist;
- Board certified Behavior Analysis or 2 years supervised experience with I/DD and extreme challenging behaviors (functional behavioral assessments, development and monitoring behavior plans).

- The implementation of the **Behavioral Consultant (II and III)** service definition is effective with the release of the July 2010 Implementation Update.

- Revision to the **Crisis Respite** service definition:
  - The purpose of the revision of the Crisis Respite definition:
    - To require the service be delivered in a Licensed Respite Facility
    - Because of current conflicts in the licensure rule for this licensure the provider is required to secure a waiver to the licensure rule prior to the delivery of the service. LME(s) should ensure this is in place when completing the endorsement review. The DMH-DD-SAS is working to make the required changes in the licensure rule.
    - To enhance the staff qualifications, and require specific training to include:
      - Complete a training course in North Carolina Interventions (NCI) (parts A & B) or similar behavioral intervention training.
      - The supervisor shall have completed a training course in NCI (parts A & B) or similar behavioral intervention training
    - **Crisis Respite Director**, specific staff qualifications required;
      - Qualified Professional,
      - Have completed a training course in NCI (parts A & B) or similar behavioral intervention training,
      - Have two years experience in the field of developmental disabilities.
  - Added the limitation to disallow individuals who live with minor children from providing services:
    - *ANY* person **living with** a minor child who is a participant, related or non-related to the minor child who is a participant, cannot provide services to the minor child.
    - Any adult family members or legal guardian who are not the child's parent (natural, adoptive or step parent) and are *not* living with the minor child who is a participant, may provide services.

- **Home Supports –clarification**
  - Home Supports is the only service that a parent living with an adult participant can provide.
  - Home Supports can be provided by a parent or other family members that are living with an adult participant in the natural family's home.

- **Individual Care Giver Training and Education-**
  - Clarification of the purpose of Individual Care Giver Training and Education;
    - Allows for caregiver to attend conferences, workshops, etc. while the participant is receiving services.
    - Case Managers **cannot** render this service.

- **Respite and Nursing Respite**
  - Nursing Respite is administered for *brief periods of time for specified needs*. It is used when the participant requires Skilled Nursing skill level of care *for specific periods of time*.
  - **Nursing Respite** at the RN level may be indicated when the participant has the following needs, indicating the *individual requires substantial and complex medical care* needs:

- The individual is receiving intravenous nutrition or drug therapy,
- The individual is dependent upon a ventilator,
- The individual is dependent on other device-based respiratory support, including tracheotomy care, and tracheal suctioning

- ❑ Revisions to the **Home Modifications** service definition to add exhaustive language and clarify limitations;
  - o The list of available modifications is exhaustive therefore other items may not be purchased with Medicaid waiver funds.
  - o $15,000 over the life of the waiver
  - o "Life of the waiver" is defined as the period between 11-1-08 and 10-31-11.
- ❑ Revisions to the **Augmentative Communication** service definition to add exhaustive language and clarify limitations;
  - o The list of available communication devices is exhaustive therefore other items may not be purchased with Medicaid waiver funds.
  - o $10,000 per waiver year
  - o Waiver year is based on the beginning of the waiver. The current waiver year is 11/1/09 to 10/31/10.
- ❑ Revisions to **Specialized Equipment and Supplies** to add exhaustive language and add financial limitations per year
  - o The list of available communication devices is exhaustive therefore other items may not be purchased with Medicaid waiver funds.
  - o $3,000 per waiver year.
  - o Waiver year is based on the beginning of the waiver. The current waiver year is 11/1/09 to 10/31/10.
  - o Specialized Equipment and Supplies which are to be used only in the school setting **may not** be purchased through the waiver. .
- ❑ **Revision to Case Management monitoring requirements**;
  - o The previous requirement (prior to July 1, 2010) for monthly face to face monitoring with the participant, has changed to, **quarterly face to face** (more frequently based on the needs of the participant) monitoring.
  - o The implementation of this change is effective July 1, 2010.

Section Two (slides 22 through 40): CAP-MR/DD Clinical Coverage Policy 8M

The CAP-MR/DD Clinical Policy contains the service definitions, the utilization review guidelines and other clinical elements of the CAP MR/DD Comprehensive Waiver and Supports Waiver.

- ❑ Utilization Review Guidelines for Residential Supports and Home Supports
- ❑ Intended to ensure participants receive the right amount of service based on their intensity of need
- ❑ "Home" refers to a participant's own home or to the home of biological/natural, adoptive, step parents (who may also be guardians of the person).
- ❑ "Residential" refers to alternative family living or provider-managed residences
- ❑ **Direct Contact Hours**
  - o Direct contact hours are defined as those spent providing direct, one-to-one, active service as justified in the Person Centered Plan.

- Direct contact hours involve ongoing demonstration by staff of personalized assistance giving practices, guidance and interaction in activities that promote opportunity for learning and achieving the goals and outcomes identified in the Person Centered Plan.
- Direct contact hours are individualized supports that are appropriate in meeting the needs of the participant and connect back to the participant's Person Centered Plan.

❑ **Waiver Services Provided by Family Members**

- Parents, other family members, or guardians of the adult participant who are paid care providers shall fulfill all of the following conditions:
  a) They shall be employed by a provider agency. They shall meet the same requirements for employment and for maintaining their employment as any other employee of that provider agency. They shall also meet all required provider qualifications as outlined in the service definition.
  b) If they are natural parents, step-parents, or adoptive parents of the participant, they shall provide only the Home Supports service. Home Supports is available only to adult participants (age 18 or older).
  c) They shall supply a clearly defined back-up plan, as required by the Person Centered Plan, that specifies who will provide the non-paid care if the parent, family member, or guardian is unable to do so.
  d) With writers of the Person Centered Plan, they shall outline measures that ensure the participant's choice and control over his or her daily life and that promote community integration. Targeted case managers shall monitor for compliance with these assurances as well as for evidence of possible social isolation and lack of participant involvement in life choices.

❑ **Waiver Services Furnished by Legal Guardians**

- Participants' legal guardians may provide waiver services to participants if they are not financially responsible for the individual. (Information regarding guardianship may be found in NCGS 35A-1202(10).) Because legal guardians have a potential conflict of interest when they are both decision makers and service providers for their wards, the following protocols are standard:
  - There is clear justification as to why the legal guardian of the person is also the provider of services. For example, there may be a lack of alternative providers; or special circumstances or considerations associated in caring for the participant noted in the Person Centered Plan may necessitate the guardian's involvement as a provider.
  - The targeted case manager shall submit written justification to the LME for provision of services by the legal guardian.
  - The LME shall review the Person Centered Plan and the justification for provision of services by the legal guardian and shall provide a decision in writing to the targeted case manager as to whether it is in the participant's best interest for the legal guardian to provide the service.
  - A legal guardian who disagrees with the decision of the LME may submit a complaint through the LME consumer complaint process

❑ **Residence**

- Participants in the CAP-MR/DD waiver reside in their own personal homes, in homes with their parents or other family members, or in out-of-home settings.
- The following describes what services may be provided in these types of residences.

- The **Natural Home** is:
  - The adult participant's own personal home or a home he or she shares with parents or other family members.
  - Both children and adult participants who reside in their natural homes may receive;
    - Personal Care Services and Home and Community Supports
    - Services are provided by staff who do not live in the participant's home
  - Adult participants residing with their parents (natural, adoptive, step-, or a combination of these) may receive:
    - Either Home Supports provided by people residing with them as indicated in Section H and I, **or**
    - Personal Care Services and Home and Community Supports provided by staff *who do not* live in the participant's home.
    - Personal Care Services and Home and Community Supports **may not** be provided on the same day as Home Supports
- **Alternative Family Living (AFL)**
    - For the purposes of the CAP-MR/DD waiver, an Alternative Family Living (AFL) home or adult foster home is considered an out-of-home setting for a person who chooses this setting.
    - The participant receives 24-hour care and lives in a private home environment with a family who are paid to provide services to address the care and habilitation needs of the participant.
    - The family will continue to reside in this home if they choose to no longer provide supports and the participant moves from their home.
    - The LME and targeted case manager are responsible for monitoring the health and safety of the participant.
    - CAP-MR/DD funds may not be used for room and board costs.
    - In a one person group home, a participant resides in a home owned or leased by another person or agency. Services are provided by caregivers who work in shifts.

- **Licensure**
  - The AFL home does not require a license if it serves only one adult with a developmental disability.
  - Any home serving more than one adult, or any number of children, requires a license (NCGS 122C-3 27G .5600F).
  - Participants who are residing in out-of-home settings may receive Residential Supports based on their need and service definition requirements
- **Unlicensed Group Home**
  - An unlicensed group home is a home which provides services similar to a licensed group home.
  - As per NC General Statute 122C-3 27G .5600C, the home does not require a license as it serves only one adult with a developmental disability who requires 24-hour supervision
- A licensed group home is defined by NCGS 122C-3 27G .5600C Supervised Living DD Adult and 27G .5600B for Minors and NCGS 131 D.

Section Three (slides 41-84): Utilization Review Guidelines

- Utilization Review is the process in which the needs of the individual are reviewed with the proposed service array to assure that services are authorized according to the needs of the individual with the limits set by the waiver and the clinical policy.
- **Utilization Review (UR) Guidelines:**
  - All services regardless of amount must be justified to assure the need for the service to aid the participant in the development of skills and strategies to increase independence and decrease the need of paid supports.
- **UR Guidelines are specific to the needs of the individual - not the rates paid for a service.**
- UR Guidelines provide the range of services available for users of CAP MR/DD services. Each service has a specific maximum limit.
- The only services which may exceed the upper limit are the non habilitative service of Personal Care or Respite.
- **These services may exceed the UR Guidelines ONLY if the services are necessary to assure the health and safety of the participant.** If services are requested to assure the health and safety of the participant, the PCP must clearly describe;
  - How the health and safety of the participant is at risk without these services, **AND**
  - Measures taken to use natural and other community supports to assure the health and safety of the individual, **AND**
  - Demonstrate that no other options are available to assure health and safety of the participant other than providing services that will exceed the UR Guidelines.
- UR Guidelines are used to determine maximum amount of services a participant may receive in total.
- **A Minimum of One Service Required Each Month. The service must be habilitative, personal care or respite.**
  - **Participants must receive at least 1(one) direct service each month to be maintained on the CAP-MR/DD waiver.** Personal care, respite and habilitative services are considered Direct Care Services. Direct service does **not** include case management, equipment or supplies.
  - CAP-MR/DD services cannot be used for recreation or for the convenience of the caregiver or provider.
- **Habilitation Maximums:**
  - Adults may receive up to 12 hours of Habilitation per day. This includes the habilitation portion of Home Supports and Residential Supports.
  - **Habilitation for Children**:
    - Any participant enrolled in public school or is between 5-15 years of age can receive **no more** than **3 hours** of CAP-MR/DD habilitation a day.
    - In total a possible **9 Hours** of CAP-MR/DD habilitative services on the day the **child does not attend school** with appropriate justification.
    - No CAP-MR/DD Habilitation Services may be utilized during the time that school is typically in session.
    - No CAP-MR/DD Service may be utilized in school- public, private or home school. This includes transportation to and from school, special equipment for school, 1:1 staff, or behavior plans written specifically for school.

- If the IEP indicates that the time the participant is in school is less than the standard school session each day, only CAP/MR-DD non- habilitative services, such as Personal Care Services or the Personal Care component of Residential Supports may be used for the remainder of the standard school day session.
- An additional **3 hours** of CAP-MR/DD habilitative services may be approved for children, if clearly justified in the approved PCP. The justification needs to show how that these additional services are necessary to maintain the current skill level.

o **Home Schooling:**

- Children who are home schooled follow the same guidelines as children who are in public or private school, however the time of the 6 hours of home schooling may differ according to the needs of the individual.
- Children who are home schooled follow the same guidelines as children who are in public or private schools
- Parents must submit the Home Schooling certificate and schedule to the Case Manager so that the Case Manager may monitor. If the family does not provide the Case Manager with the Home Schooling schedule, the child will use the same schedule as public school

Guidelines for individuals who are living in their own home or in their natural home and are not receiving Home Supports:

Service	**LEVEL 1 SNAP** Index 24-44	**LEVEL 2 SNAP** Index 45-78	**LEVEL 3 SNAP** Index 80-94	**LEVEL 4 SNAP** Index 95-230
Personal Care Services	40 hr/month (160 units)	80 hr/month (320 units)	120 hr/month (480 units)	180 hr/month (720 units)
Respite**	576 hours/year	576 hours/year	576 hours/year	576 hours/year

Habilitative Services (Individualized Day Program, Day Supports, Supported Employment, and LT Vocational Support)	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services

Respite – 576 Hours per year
Habilitation – 120 hours per month in total

Guidelines for Individuals who are living in their natural homes with their families and are receiving Home Supports:

Service	**LEVEL 1 SNAP** Index 24-44	**LEVEL 2 SNAP** Index 45-78	**LEVEL 3 SNAP** Index 80-94	**LEVEL 4 SNAP** Index 95-230	**LEVEL 5 SNAP** Index 125-230
Home Support Residential Support	Separate Grid	Separate Grid	Separate Grid	Separate Grid	Separate Grid
Respite AFL and Home Support only**	576 hours/year	576 hours/year	576 hours/year	576 hours/year	576 hours/year
Habilitative Services (Individualized Day Program, Day Supports, Supported Employment, and LT Vocational Support) Includes Habilitation hours that are part of Home Supports or Residential Supports	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services	120 total hours/month for any combination of these services

*Direct Contact hours is defined as the amount of time that is spent providing direct one-one, active service and does not include general supervision and monitoring.

HOME SUPPORT AND RESIDENTIAL SUPPORT GRIDS

The rate for Home Supports Level 1 is based on 4 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Home Supports Grid Level 1 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
4.0	0.50	4.5
3.0	2.00	5.0
2.0	3.50	5.5

The rate for Home Supports Level 2 is based on 6 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Home Supports Level 2 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
6.0	0.5	6.5
5.0	2.0	7.0
4.0	3.5	7.5
3.0	5.0	8.0
2.0	6.5	8.5

The rate for Home Supports Level 3 is based on 7 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Home Supports Level 3 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
7.0	**0.5**	**7.5**
6.0	**2.0**	**8.0**
5.0	**3.5**	**8.5**
4.0	**5.0**	**9.0**
3.0	**6.5**	**9.5**
2.0	**8.0**	**10.0**

The rate for Home Supports Level 4 is based on 8 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Home Supports Level 4 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
8.0	**0.5**	**8.5**
7.0	**2.0**	**9.0**
6.0	**3.5**	**9.5**
5.0	**5.0**	**10.0**
4.0	**6.5**	**10.5**
3.0	**8.0**	**11.0**
2.0	**9.5**	**11.5**

The rate for Home Supports Level 5 is based on 12 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Home Supports Level 5 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
12.0	**0.5**	**12.5**
11.0	**2.0**	**13.0**
10.0	**3.5**	**13.5**
9.0	**5.0**	**14.0**
8.0	**6.5**	**14.5**
7.0	**8.0**	**14.0**
6.0	**9.5**	**15.5**
5.0	**11.0**	**16.0**
4.0	**12.5**	**16.5**
3.0	**14.0**	**17.0**
2.0	**15.5**	**17.5**

Guidelines for individuals who are living in group homes, AFLs, or one person group homes:

The rate for Residential Supports Level 1 is based on 4 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Residential Support *Levels of Support* Residential Supports Grid Level 1 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
4.0	**0.5**	**4.5**
3.0	**2.0**	**5.0**
2.0	**3.5**	**5.5**

The rate for Residential Supports Level 2 is based on 6 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Residential Supports Level 2 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
6.0	**0.5**	**6.5**
5.0	**2.0**	**7.0**
4.0	**3.5**	**7.5**
3.0	**5.0**	**8.0**
2.0	**6.5**	8.5

The rate for Residential Supports Level 3 is based on 7 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Residential Supports Level 3 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
7.0	**0.5**	**7.5**
6.0	**2.0**	**8.0**
5.0	**3.5**	**8.5**
4.0	**5.0**	**9.0**
3.0	**6.5**	**9.5**
2.0	**8.0**	**10**

The rate for Residential Supports Level 4 is based on 8 hours of habilitation and ½ hour of personal care. Knowing that individuals need different combinations of habilitation and personal care, the grid shows the amount of each component of the service required to equal the base rate, *and* provides options to meet the needs of the individual.

Residential Supports Level 4 Per Diem Service Options for Provision of Direct Contact Hours		
Hours of Habilitation	**Hours of Personal Care**	**Total Hours**
8.0	**0.5**	**8.5**
7.0	**2.0**	**9.0**
6.0	**3.5**	**9.5**
5.0	**5.0**	**10.0**
4.0	**6.5**	**10.5**
3.0	**8.0**	**11.0**
2.0	**9.5**	**11.5**

- **Exceeding the Utilization Review Guidelines:**
  - If services and supports are requested to assure the health and safety of the participant, the PCP must clearly describe how this is to be addressed
  - Only non-habilitative services (Personal Care or Respite) services may exceed the UR Guidelines.
  - Individuals residing in AFLs may not exceed the UR Guidelines.
- **NC SNAP**

- There should be a positive correlation between the SNAP core and the required number of direct contact hours.
- When the SNAP score and the direct contact hours needed do not show a relationship, justification within the PCP and supporting documentation is required.

Section Four (slides 85-101): Due Process Rights

- Participants have due process rights as follows:
  - Persons whose requests for waiver services are denied, reduced, terminated or suspended; denied the provider of their choice; or, denied LOC are issued a written notice that states the adverse action, citation supporting the action, and due process of appeal rights for a fair hearing or formal appeal conducted by the Office of Administrative Hearings (OAH).
  - If a consumer is not receiving services, OAH will expedite the hearing request.
  - This notice must be mailed at least 10 days prior to the effective date of the adverse action.
  - If the recipient chooses to appeal the decision, he/she has 30 days from the date the notice is mailed to appeal the decision.
  - Should the recipient appeal within the mandated timeframe and should the recipient currently receive services, those services continue for the pendency of the appeal.
  - N.C.G.S. 150B-31.2(c) allows each recipient to be offered mediation prior to a fair hearing. This mediation takes place outside of OAH.
  - If the mediation successfully resolves the case to the recipient's satisfaction, the case is dismissed.
  - Should the recipient reject the offer of mediation or the mediation is unsuccessful, the case proceeds to fair hearing.
- **Implementation Plan**
  - The new policies contained in Clinical Policy and Technical Amendment Number One **will be effective February 1, 2011 unless otherwise noted.**
  - Participants, guardians and legally responsible persons will have this time to determine alternate support options to ensure the health and safety needs are adequately addressed.
  - Case managers will work with participants/legally responsible persons to assess the participants' needs and make any needed changes to the participant's person centered plan to meet the new requirements while ensuring services and supports are adequate to meet the health and safety needs of the participant.
  - In the event a participant cannot make the transition to the policy changes by the February 1, 2011 effective date, the DMH-DD-SAS will review the participant's person centered plan and determine if further time is required or if other actions are necessary for the participant to safely make the transition.
  - Other actions may include the case managers securing alternate generic/natural services and supports, etc.
  - The DMH-DD-SAS will work with the LME(s) and case managers to ensure the participants' health and safety needs are met.
  - The PCP Review Process for individuals who are unable to make the needed changes as required by February 1, 2011 is as follows**:**
    - The case manager must send the LME the request for an extension or exception **by December 1, 2010.** The request will contain the revised PCP with any/all documentation and justification as to the specific health and safety issues and reasons why the individual cannot meet the transition requirements. The revised PCP must

also include all paid and non paid services/supports beyond CAP-MR/DD that the participant is currently receiving.

- The LME will review the request for an extension or exception, including the revised PCP and discuss with the case manager the specific health and safety issues preventing transition as required by February 1, 2011 and possible alternatives to address the individual's support needs.
- **The LME must submit the required information to the DMH-DD-SAS by January 1, 2011.**
- The DMH-DD-SAS designated PCP review staff will review the revised PCP and accompanying documentation/justification and discuss with the LME and case manager if appropriate.
- If the DMH-DD-SAS designated PCP review staff determine the individual has health and safety risks that may be affected by the required transition an extension or exception may be granted. An extension or exception may be granted **ONLY if the services are necessary to assure the health and safety of the participant.** If services are requested to assure the health and safety of the participant, the PCP must clearly describe;
  - how the health and safety of the participant is at risk without these services, **AND**
  - measures taken to use natural and other community supports to assure the health and safety of the individual, **AND**
  - Demonstrate that no other options are available to assure health and safety of the participant other than providing services that will exceed the UR Guidelines.
- Within 15 days from receipt the DMH-DD-SAS designated PCP review staff will provide the LME with a written response regarding the request for the extension or exception. The Division will send notice of appeal rights to all individuals for which exceptions that have been denied. The LME will notify Case Managers of the decision made regarding the extension.

- **CAP-MR/DD Waiver Manuals**
  - The manuals are thorough in presenting information in a user friendly manner.
  - There is much more detail then in past manuals making the manual a useful resource for all parties involved in the waivers.
  - Significant effort occurred in the development of the manuals to ensure the information corresponds with the Clinical Policy.
  - When the complete text is not included in the manuals, the resource of where to locate the information is provided to ensure the manual user will have access to the most current information by using links to appropriate websites.
- Revisions and Addendums to the Manuals:
  - The Division (DMA and DMH-DD-SAS) will provide any future Manual Addendums as needed on a bi-annual basis.
  - Notification of Manual Addendums will be provided in an Implementation Update.